



# HEBREW ACADEMY

## EARLY CHILDHOOD DIVISION



Dear Parents,



**Welcome to the Hebrew Academy Preschool family!**

**We are pleased to announce that registration for the upcoming 2026-2027 school year is now open.**



Our mission is to provide your child with a nurturing, Torah-based "home away from home" fostering a lifelong love of learning in a fun and supportive environment.

### **Program Details:**

#### **Start time:**

9:00 a.m.. (Early drop-off available at 8:20 a.m. for an additional fee.)

#### **Dismissal Options:**

Two and three-year-olds 12:20 p.m. 1:45 p.m. and 3:15 p.m.  
Four-year-olds 1:45 p.m. or 3:15 p.m.



### **New Families:**

*Please meet with Rabbi Simcha Dessler and then complete the following steps:*

1. Complete online application using this link: <https://portal.admirepro.com/hac/apply>
2. Print out and complete preschool registration forms 1-5, ensuring all red-arrowed lines and required signatures are filled out.
3. Submit the forms along with Medical and immunization records to the preschool office. Out of town families may email completed forms as an attachment to [schiffb@hac1.org](mailto:schiffb@hac1.org)



### **New Children of Current Families**

*Please complete the following steps:*

1. Complete the online application using this link: <https://portal.admirepro.com/hac/apply>
2. Print and complete registration forms 1-5, ensuring all red-arrowed lines, signatures and medical and immunization records are included.
3. Submit the forms to our preschool office.



### **Currently Enrolled Students**

All current student's registration will Bez"H automatically roll over in March and paper work for them will be sent out then.

### **Important Information**

**Only children with complete registrations will be admitted. This includes both online registration and the printed and completed Early Childhood Registration Forms. Children entering our three-year-old program must be toilet trained.**



*We look forward to an amazing year of growth, learning and fun. Please feel free to contact us with any questions.*



**Mrs. Rivky Wolf**

*Administrator*

**Mrs. Rochel Garfinkel**

*Assistant Administrator*

1800 Warrensville Center Road • Cleveland, Ohio 44121

**PHONE:** (216)382-3300 EXT. 270 **EMAIL:** [wolfra@hac1.org](mailto:wolfra@hac1.org)

# APPLICATION FOR REGISTRATION

➔ Child's name (last and first) \_\_\_\_\_  
First name you want your child to be called in school \_\_\_\_\_  
Spelling in Hebrew \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_ Date of birth \_\_\_\_\_ Does your child have an IEP? \_\_\_\_\_  
If the answer is yes, the IEP needs to be attached.

## ARRIVAL AND DISMISSAL TIMES

➔ **Arrival Time (Please select one):**  
 9:00  
 8:20-Early Drop-Off. (For an additional fee) Limited slots available. They are filled on a first come, first serve basis.

➔ **Dismissal Time (Please select one):**  
 12:20 (2 and 3 year olds only)  
 1:45  
 3:15

## ➔ FRIEND REQUEST

Please list one or two friends you would like your child to be with. (We will try our best to accommodate.)

\_\_\_\_\_

## ➔ PHOTO RELEASE

I allow my child's photographs to be published.  
 I don't allow my child's photographs to be published.

## ➔ ANY ADDITIONAL INFORMATION FOR US TO BE AWARE OF

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have completed the online portal registration.

➔ Parent's Signature \_\_\_\_\_

Administrator's notes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ohio Department of Job and Family Services  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE**

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

Child's Name		Date of Birth		First Day at Program/Home 8/25/26	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State		Zip	
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell# <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State		Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell# <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> as emergency contacts. List the name of <b>at least one person</b> who can be contacted in the event of an emergency or illness <b>if you cannot be reached</b> . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State		City	
State		City		State	
Telephone Number		Relationship to Child		Telephone Number	
Relationship to Child		Telephone Number		Relationship to Child	
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State		Telephone Number	

2B

Child's Name

**Allergies, Special Health or Medical Conditions, and Medical Foods**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

- No  
 Yes - *check all that apply*     Food     Medication     Environmental    Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No  
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

- No  
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

- No  
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

- No  
 Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

- No  
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

- No  
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No  
 Yes - written instructions from the child's health care provider must be on file.  
 N/A - program does not provide meals or snacks to the child.

2C

Child's Name

**Diapering Statement**

Is your child toilet trained?  Yes (If yes, skip to Emergency Transportation Authorization section)  
 No (If no, fill out the following:)

The program's policy is to check diapers every 2 hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

I agree with the program's schedule  I do not agree, please check my child's diaper every \_\_\_\_\_ hours.

**Emergency Transportation Authorization**

<b>Give <u>Permission</u> to Transport</b>		<b>OR</b> <b>Do not sign both</b>	<b><u>Do Not Give Permission</u> to Transport</b>	
Program or Home Name			Program or Home Name	
<b>has permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			<b>does not have permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date 8/25/26		Parent's Signature	Date

**Acknowledgement of Policies and Procedures**

I have reviewed and received a copy of the program's or home's policies and procedures/handbook.  Yes  No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date 8/25/26
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

**Note:**

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or **medical personnel** in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Ohio Department of Job and Family Services  
**ROUTINE TRIP PERMISSION FOR CHILD CARE**

<b>Routine Trip Information</b>	
Routine Trip Destination(s) Walks around the neighborhood	
Date of Permission ( <i>valid for one year</i> ) 8/25/2026-6/30/2027	
Mode of Transportation ( <i>walking, school bus, public transportation, parent vehicles, provider vehicle and driver</i> ) Walking	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? (if yes, a swimming permission slip is required) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>Child's Information</b>	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
<b>Signature</b>	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date 8/25/2026



Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )	Date of Birth
<b>Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):</b>	
<b>Section A- EXAMINATION</b>	
√ The above named child has been examined.	
√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).	
√ The above named child does not have allergies OR is allergic to the following ( <i>please list in space below</i> ):	
<i>Check below, if applicable:</i>	
<input type="checkbox"/> Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.	
Optional: Measurements and Recommended Assessments/Screenings	
Height _____	Vision _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Weight _____	Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other: _____
<b>Signature of Examining Health Care Practitioner</b>	<b>Date of Examination</b>
<b>Name of Examining Health Care Practitioner</b>	<b>Telephone Number</b>
<b>Street Address</b>	<b>City, State and Zip Code</b>

**ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.**

<b>IMMUNIZATION (Complete ONLY ONE SECTION below)</b>	
<b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b> Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
<b>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</b>	<b>Initials of Examining Health Care Practitioner</b>
<input type="checkbox"/> The above named child has been immunized against the diseases listed above.	
<i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i>	<b>Date</b>
<b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b>	<b>Signature of Parent</b>
<input type="checkbox"/> I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	
	<b>Date</b>

According to Ohio State Law, all early childhood students are required to have an-up-to date medical exam and immunization records on file.

Please submit the attached Child Medical Statement along with your child's immunization records, to the preschool office upon completing your child's registration.